State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

DEPARTMENT OF HUMAN SERVICES

ANN SILVERBERG WILLIAMSON
Executive Director

MARK L. BRASHER
Deputy Director

LANA STOHL
Deputy Director

Thank you for making contact with us. We are looking forward to getting to know you. We hope we can help you get the services that you need. We provide services for people with intellectual disabilities and closely related conditions, acquired brain injury, and physical disabilities.

We have enclosed the following documents with this letter:

- Intake Checklist
- Form 1-1 Request for Determination of Eligibility for Services
- Intake Social History
- Division of Services for People with Disabilities Needs Assessment
- Form 1-2 Authorization to Furnish Information and Release from Liability
- Frequently Asked Intake Questions
- Community Supports Waiver Fact Sheet (English)
- Community Supports Waiver Fact Sheet (Spanish)
- Family to Family Network

Please complete the items on the Intake Checklist and return them to us using the information below:

Division of Services for People with Disabilities
Intake Unit
475 West Price River Drive #262
Price, UT 84501-2858

DSPDIntake@utah.gov

Fax: 435-637-8384

If you have any questions or need help completing the attached forms, please contact the Intake Help desk at 801-538-4200 #1.

We look forward to receiving your application.

Jeff Blanc
Intake Coordinator
Utah State Division of Services for People with Disabilities

Division of Services for People with Disabilities
Intellectual Disabilities and Related Conditions Intake Checklist

_____ Form 1-1 - Request for Determination of Eligibility for Services

_____ Social History

_____ Release of Information

_____ Copy of Social Security Card

_____ Copy of Birth Certificate

_____ Copy of Medicaid Card – *If not applicable, please indicate in the Social History*

_____ Social Security Income – *If not applicable, please indicate in the Social History*

_____ Psychological Evaluation with Diagnosis – For children under seven years of age, a Developmental Assessment may be used as an alternative. The assessment must be completed within the last five years

_____ Medical Records – Relevant information related to disability, including a diagnosis and corresponding ICD-10 Code

When the above documentation is received and reviewed, an appointment will be set up to complete an assessment (ICAP).

Please mail, email, or fax documentation to:

Division of Services for People with Disabilities
Intake Unit
475 West Price River Drive #262
Price, UT 84501-2858

DSPDIntake@utah.gov
Fax: 435-637-8384

Please feel free to contact the Intake Line if you have questions.
801-538-4200 #1

If you are interested in registering to vote, go to: https://secure.utah.gov/voterreg/index.html

Form 1-1 REQUEST FOR DETERMINATION OF ELIGIBILITY FOR SERVICES

Information on APPLICANT (Person with Disabilities): [Please print the following information]			
First Name	Middle Name		Last Name
Home Phone	Work Phone		Cell Phone
Date of Birth	Gender Male Female		Social Security No
Address			City
County	State	Zip Code	e-mail

I, the Applicant, understand that by signing below and returning this form I am officially requesting the Division of Services for People with Disabilities to collect information about me to see if I am eligible for services.

_____ and/or _____ _____

Applicant's signature *Parent/Guardian's signature* *Date*

CONTACT PERSON (if different than applicant):		
Name	Phone Number	Relationship to Applicant

Please return this form to start the eligibility process. If you need help completing this form, please contact Janet Kinder 475 W Price River Dr #262 Price, UT 84501 at 435-636-2393 from 8:00 a.m. to 5:00 p.m., Monday through Friday. Or you can scan and email this form to DSPDIntake@utah.gov.

Division of Services for People with Disabilities

Intake Social History

Today's Date:_____/_____/_____
MM DD YYYY

1. Applicant's Personal Information

First Name	Middle Initial	Last Name
Nickname	Date of Birth	

Race	Ethnicity
American Indian/Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Caucasian ☐ Asian ☐ Other ☐	Hispanic/Latino Yes ☐ No ☐

Primary Way of Communicating	Primary Language	Need for a Translator?
Speaking ☐ Other ☐		Yes ☐ No ☐ Language:_____

2. Applicant's Physical Address (Where the applicant currently resides)

Address			
City	State	County	Zip Code

3. Applicant's Mailing Address (if different)

Address			
City	State	County	Zip Code

4. Applicant's Telephone Number(s) and Email Address (if applicable)

Home Phone	Mobile/Cell Phone	Email Address

5. Primary Persons of Contact (Please list all legal guardians if applicable and one person who does not live with the Applicant)

Name	Date of Birth	Lives with Applicant?	Relationship to the Applicant
		Yes ☐ No ☐	
Address			
City	State		Zip Code
Home Phone	Work Phone	Mobile/Cell Phone	Email Address

Are you the Applicant's legal or court appointed legal guardian? Yes ☐ No ☐
If yes, please provide a copy of the guardianship papers if the Applicant is not a minor child.
If no, list the Applicant's legal or court appointed guardian if applicable._____
Are you in need of a translator? Yes ☐ No ☐ If yes, what language:_____

Primary Persons of Contact (cont.)

Name	Date of Birth	Lives with Applicant?	Relationship to the Applicant
		Yes ☐ No ☐	
Address			
City	State		Zip Code
Home Phone	Work Phone	Mobile/Cell Phone	Email Address

Are you the Applicant's legal or court appointed legal guardian? Yes ☐ No ☐
If yes, please provide a copy of the guardianship papers if the Applicant in not a minor child.
Are you in need of a translator? Yes ☐ No ☐ If yes, what language:_____

Primary Persons of Contact (If applicable or needed)

Name	Date of Birth	Lives with Applicant?	Relationship to the Applicant
		Yes ☐ No ☐	
Address			
City	State		Zip Code
Home Phone	Work Phone	Mobile/Cell Phone	Email Address

Are you the Applicant's legal or court appointed legal guardian? Yes ☐ No ☐
If yes, please provide a copy of the guardianship papers if the Applicant in not a minor child.
Are you in need of a translator? Yes ☐ No ☐ If yes, what language:_____

6. Applicant's Educational History (Please list the current or last school attended)

Name of School	Type of School	Contact Information

Does/did the applicant receive early intervention services? Yes ☐ No ☐
Does/did the applicant receive special education services? Yes ☐ No ☐
If still in school, when will the applicant transition out? _____
MM/YYYY

7. Applicant's Employment History (FOR AGES 16 AND OVER)

(Please list Applicant's most recent job)

Employer	Avg. Hours/WK	Hourly Wage	Nature of Work	Start Date	End Date
			Paid with benefits ☐ Paid without benefits ☐ Volunteer/Unpaid ☐		
Job Title/Description:					
Type of Employment (please check one): Integrated Employment: Individual (e.g. Applicant holds/held own job in the community ☐ Work Crew (e.g. Applicant holds/held own job in the community as part of a work crew) ☐ Facility-Based (i.e. participated in a sheltered workshop, work activity, etc.) ☐					
Work Related Issues (i.e. problems with reliability, other employees, employer, etc.):					
Work Related Successes, Special Skills, etc.:					

Has the Applicant received Supported **Employment through Vocational Rehabilitation?** Yes☐ No☐
If yes, what year did the Applicant **receive Vocational Rehabilitation services?** _____
Is the Applicant seeking employment **that would require ongoing support?** Yes☐ No☐
Does the Applicant currently have an **open case with Vocational Rehabilitation?** Yes☐ No☐
If yes, which office:_____ Contact number:_____

8. Areas of Concern **(List any major health, psychological, substance abuse related or physical, other related problems, and diagnosis that currently affect the Applicant's life)**

Area of Concern	Receiving Support?	Need Support?	If marked yes, please describe the concern
Behavioral	Yes☐ No☐	Yes☐ No☐	
Mental Health	Yes☐ No☐	Yes☐ No☐	
Medical/Health Related	Yes☐ No☐	Yes☐ No☐	
Substance Abuse	Yes☐ No☐	Yes☐ No☐	
Safety	Yes☐ No☐	Yes☐ No☐	
Other	Yes☐ No☐	Yes☐ No☐	

9. Brain Injury **(Has the Applicant suffered a brain injury):**
Yes☐ No☐ **If yes, please answer the following questions)**

When (what date) did the brain injury occur? _____	Did the brain injury occur pre or post birth? Pre☐ Post☐
Describe the cause of the brain injury:	

10. Applicant's Use of Medical/Specialized Equipment **(e.g. wheel chair, walker, g-tube, etc.)**

Does the Applicant currently use any specialized equipment? Yes☐ No☐

If yes, please describe the specialized equipment used.

11. Applicant's Recent Hospitalizations **(Please list any hospitalizations within the past year including psychiatric/residential hospitalizations including the Utah State Hospital)**

Name of Facility	Reason for Admittance	Treatment Start Date	Discharge Date

12. Applicant's Stay in a Nursing Facility (NF) or Intermediate Care Facility (ICF/ID)

Is the Applicant now, or have they ever been a resident of a Nursing Facility? Yes ☐ No ☐

Is the Applicant now, or have they ever been a resident of an ICF/ID? Yes ☐ No ☐

If yes, please enter the following information:

- Admission Date _____
- Name of the Facility _____
- Discharge Date _____

13. Agencies (Is the Applicant involved with any city, state, or federal agencies? If so, enter the following)

Name of the Agency	Agency Contact Person	Agency Phone Number	Email Address
Division of Child and Family Services (DCFS)			
Adult Protective Services			
Office of Public Guardian			
Veteran Affairs (VA)			
Juvenile Justice Services			
County Aging Services			
Mental Health			

14. Applicant's Professional Relationships (This includes Doctors, School Representative, Speech or Occupational Therapist etc., not listed in section 14)

Professional's Name	Type of Professional	Phone Number	Email Address

15. Court Orders/Court Involvement (Is the Applicant currently affected by any court orders? If so please list)

What Kind of Order is it?	Date of the Order

16. Applicant's Benefits (If the Applicant receives a benefit, enter the following information)

Type of benefit (e.g. earned, retirement, Social Security, etc.)	Amount	Frequency the benefit is received? (e.g. weekly, monthly, one–time, etc.)

17. Does the Applicant receive Medicaid or Medicare benefits?

Insurance Type	Insurance Identification Number
Medicaid: Yes ☐ No ☐	
Medicare: Yes ☐ No ☐	

Social History Completed By: _____ Date: _____

Assessed by:_____ **Date:**_____
Consumer Name:_____ **PID:**_____

Section 1. Urgency of Need (U) (to be completed by the worker on all new intakes and re-score requests. This section is not completed as part of the annual waiting list survey.)

U1. After following up with APS/CPS in the case of a positive electronic match, is the applicant a good candidate for ESMC referral?	**YES**	**NO**
U2. Has the applicant been court ordered to receive services?	**YES**	**NO**
U3. Has the applicant been approved for funding under a cooperative agreement?	**YES**	**NO**
U4. Is the applicant either currently, or at risk of in the next 30 days, living on the street or in a homeless shelter?	**YES**	**NO**
U5. Is the applicant at risk of profoundly endangering self or others in the next 30 days? (i.e. death, dismemberment, permanent injury)	**YES**	**NO**
U6. Is the applicant without a caregiver to meet his/her life-sustaining needs?	**YES**	**NO**
U7. Is the applicant at risk of not having a primary caregiver in the next 30 days?	**YES**	**NO**

Section 2. Severity of the Applicant's Disability (A) (to be completed by the family with assistance from the worker if needed). Workers are responsible for confirming responses and documenting supporting evidence when needed.

A1. If over the age of 10 years, for how many hours can the applicant be left home alone? (check one)
___0 hours ___1-3 hours ___4-7 hours ___8-12 hours ___13+ hours

A2. How many hours do family members/household members spend providing supports to the applicant (not including time when the applicant is asleep, at school/work, or at another activity outside of the home)?
_____ HOURS PER (DAY WEEK MONTH)
(Enter a number) *(circle one)*

A3. Which of the following tendencies does the applicant currently have (check all that apply):
____Hurtfulness to self/others: Kicking, biting, pinching. poking, head-banging, stabbing, hair-pulling, or otherwise leaving a lasting physical mark (i.e. red skin, bruises, bleeding) visible within an hour or later time either to the individual themselves, another person, or an animal.
____Property destruction: Ripping, burning, taking apart, or otherwise permanently making useless and necessitating replacement of a possession belonging to the applicant or someone else.
____Running/Bolting: Quickly disappearing from the caregiver's supervision with the threat of injury present. For example, an individual who runs out of their house and perhaps runs into traffic.
____Social offensiveness: Urination, defecation, expectoration (spitting), yelling/screaming, using crude language or gestures, exposing of genitals, touching or talking to others in a sexual manner, self-touching of genitals, or otherwise exhibiting lewd behavior in the company of another person.

A4. For how many hours do caregivers spend providing medical assistance to the applicant? (includes: administering medications, treatments, therapy, transporting to/attending doctor/dental appointments)
_____ HOURS PER (DAY WEEK MONTH)
(Enter a number) *(circle one)*

A5. Does the applicant have any unmet medical needs? **YES** **NO**
If yes, explain (continue at bottom of form if needed):

Definitions:
The **applicant** is the person with a disability applying for DSPD services.
A **caregiver** is anyone who provides supports to the applicant.
The **primary caregiver** is the person who provides the majority of supports to the applicant.
The **household** includes anyone living in the same dwelling as the applicant.
Supports includes paying bills, supervising (while the applicant is awake), helping clean, transporting, completing forms, shopping, grooming, or otherwise caring for the applicant.

Section 3. Parental/Caregiver Ability (C) (to be completed by the family with assistance from the worker if needed). Workers are responsible for confirming responses and documenting supporting evidence when needed.

C1. Is the primary caregiver a paid caretaker (i.e. applicant lives in supported/assisted living setting, group home, or with a paid caretaker)? ***(circle one)*** **YES** **NO**
→If "YES", you may skip questions C2-C6 and return this form now.
→If "NO", answer questions C2-C5 do be evaluated for poverty level. **Leaving any question blank** will result in disqualification for poverty consideration and **could have a negative impact on your waiting list placement.** Also answer question C6 if applicable.

C2. What is the *household*'s annual gross (before taxes) income (enter a dollar amount). $_____

C3. How much does the household/family pay (out of pocket) in medical expenses each month for the applicant? **Includes co-payments for office visits and other out-patient treatments, hospitalizations, prescriptions, over the counter medicines, ointments, creams, incontinence garments/pads, diapers (if over the age of 3 years), dietary supplements if prescribed by a medical provider, and Medicaid spend-down.** $_____

C4 What is the household size (including the applicant)? _____

C5. How many individuals in the household are under 18 (including the applicant if applicable)? _____

C6. Does the caregiver have any of the following limitations ***(check all that apply)***
____**Only one potential caregiver (i.e. single parent, only 1 competent adult relative in vicinity).**
____**Someone else in the house other than the applicant needs daily one-on-one intense care (not including young children UNLESS they have a disability).**
____**The household does not have a working and registered automobile (and public transportation does not meet the applicant's needs).**
____**Caregiver has a history of perpetrating abuse, neglect, or exploitation.**
____**Caregiver is over the age of 59 years.**
____**Caregiver is undergoing treatment for cancer or other terminal illness.**
____**Caregiver has a condition related to heart, blood pressure, or ulcers exacerbated by stress.**
____**Caregiver has arthritis, scoliosis, fragility, brittle bones, or is small in stature and the applicant needs lifting/carrying at times.**
____**Other significant barriers to caring for the applicant.**
Explain (continue at bottom of form if needed):

Section 4. Time Without DSPD Services (T) (system-generated based on time spent waiting whether with a future or immediate need.)

T1. For how many months has the applicant been waiting for DSPD services? _____

Additional Comments:

Definitions:
The **applicant** is the person with a disability applying for DSPD services.
A **caregiver** is anyone who provides supports to the applicant.
The **primary caregiver** is the person who provides the majority of supports to the applicant.
The **household** includes anyone living in the same dwelling as the applicant.
Supports includes paying bills, supervising (while the applicant is awake), helping clean, transporting, completing forms, shopping, grooming, or otherwise caring for the applicant.

8/15 Form 1-2

AUTHORIZATION TO FURNISH INFORMATION AND RELEASE FROM LIABILITY

Name:_____ DOB: _____

I am: ☐ The individual named above ☐ The individual's legally authorized personal representative

The following have my permission to disclose my protected health information:

☐ Alpine, Box Elder, Cache, Carbon, Canyons, Daggett, Davis, Duchesne, Emery, Grand, Jordan, Logan City Nebo, Provo, Salt Lake, Sevier, San Juan, Rich, Summit, Uintah, Utah, Weber and Wasatch School Districts:
☐ Division of Rehabilitation Service:
☐ Mental Health Centers listed: _____
☐ Physicians and Psychologist as listed:
_____
_____
_____
_____

You are hereby authorized to release to the **Department of Human Services Division of Services for People with Disabilities (DSPD)** or its authorized representatives, verbally or in any written form, any information you have regarding the following subjects:

☐ Developmental Testing ☐ Brain Injury Records ☐ Vocational Testing
☐ Psychological/Cognitive Tests ☐ Inpatient /Outpatient Records ☐ IEP/Educational Testing
☐ Outpatient Records ☐ Physical Examination Records ☐Other:_____

Please include records from: _____ to _____

(*Recipient Information: If the information released related to drug or alcohol abuse, the records are protected by federal confidentiality laws and you are prohibited from making further disclosures of this information without the specific written authorization of the person of whom it pertains or as permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. Federal law restricts using drug or alcohol abuse information for criminal investigation or prosecution.)

The purpose of this disclosure is:

☐ To establish eligibility for DSPD services ☐ Expiration Date (please specify):_____

- I understand that I may refuse to sign this Authorization, and my health care provider cannot refuse to provide treatment, payment or deny eligibility for benefits based upon my refusal.
- I understand that I may revoke this authorization in writing at any time. I understand that my revocation is not effective until received by the health care provider. My revocation is not effective to the extent the health care provider already released information in reliance on this authorization.
- I understand that federal privacy laws may no longer protect information released to DSPD and the information may be re-disclosed.
- I understand that this information is required by the Department of Human Services for the Division of Services for People with Disabilities.

I, the Individual and/or Authorized Personal Representative, understand that by signing below am requesting the Division of Services for People with Disabilities to collect information about me to see if I am eligible for services.

Individual's Name *(printed)*: _____

Individual's Signature/Date: _____

Authorized Personal Representative's Name *(printed)*: _____

Authorized Personal Representative's Name *(printed)*: _____

Frequently Asked Intake Questions

you. The intake worker will set up what is called an ICAP assessment, which determines where the most support is needed. This is part of the eligibility process.

Q: How will I know when a decision has been made?

A: Once all documentation is received and reviewed, an informational letter called a Notice of Agency Action (NOAA) will be sent to you. This letter will state whether the applicant is eligible (and placed on the waitlist) or ineligible for DSPD services.

Q: What happens if I am Ineligible?

A: You will be sent an informational letter (NOAA) that will let you know in writing that you are not eligible for services. Attached to all Notice of Agency Actions is a Hearing Request form. You can request to appeal the decision made by DSPD on this form, however it needs to be returned to DSPD within 30 days of the postmark. You can contact DSPD if you have questions regarding the appeal form.

Q: What happens if I am eligible?

A: You will be sent an informational letter (NOAA) that will let you know in writing that you are eligible for services. This letter will include a Hearing Request form which is included whenever a Notice of Agency Action is sent. You do not need to return the appeal form if you are found eligible for services.

Q: How long will I be on the waiting list?

A: Funding is provided to those with the most critical needs. DSPD does not work on a first come first serve basis. Placement on the waitlist is primarily based on need, and wait times vary according to need and available funds. For more specific information you can contact your intake worker or visit the DSPD website.

Q: How does DSPD follow up with people on the waiting list?

A: Every year DSPD will send a survey to you in the mail. This survey is used to determine your current need, as well as let DSPD know you are still interested in our services. These surveys are sent through the mail so it is important to keep your contact information up to date with your waitlist worker. *If we do not receive a response to this survey, you will be taken off the waitlist.* You can contact your intake worker at any time to update your situation, or check on your status. If you discover you are no longer on the waitlist because you did not respond to the survey, you can contact our intake line at 1-877-568-0084.

Q: What happens when I come off of the wait list?

A: Once we receive funding for your case, all documentation provided to DSPD will be reviewed again, and you will be contacted by a waitlist worker to update any necessary information. You will go through a process similar to the original intake process and may be required to submit additional documentation to re-determine eligibility. You will be transitioned to a state support coordinator who will assist you with available services.

For information about Medicaid please visit: http://medicaid.utah.gov/
For information about ICF/ID or Care Centers please contact:
http://www.health.utah.gov/ltc/CS/CSLinks.htm click on "Community Supports Facts Sheet"

For any additional questions about DSPD services, please contact your intake worker or visit the DSPD website at: http://www.hsdspd.utah.gov